Trauma Informed Care
A History of Helping: A History of Excellence

Lessons Learned Since 1990

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Dr. Steele founded the National Institute for Trauma and Loss in Children™ (TLC) in 1990 long before children were included in the diagnostic category of Posttraumatic Stress Disorder (PTSD). He began developing and researching trauma specific interventions in 1990 beginning with a one-session trauma specific intervention. Today his model Structured Sensory Interventions for Traumatized Children, Adolescents and Parents (SITCAP™) is used in thousands of schools and agencies across the country and undergoes continuous field testing and rigorous evidence-based research. Outcomes have consistently demonstrated remarkable, statistically significant reductions of trauma and associated mental health symptoms. Over 5,000 professionals have been certified as Trauma and Loss Specialists by TLC under Dr. Steele's supervision. He encourages you to visit TLC's website (www.tlcinstitute.org) for more detailed information.

Given past and recent research about trauma in addition to twenty years of experiences working with traumatized children and adolescents, adults, families, schools and communities, the following lessons learned have been integrated into the evidence based SITCAP™ model. They represent what we know about trauma as an experience and provide the core sensory focus trauma specialists must use to guide and structure their interventions. Intervention must be very structured and directed at sensory/implicit functions that lead to the diminishing and eventual replacement of the trauma related sensory memories in order to reframe those experiences in ways traumatized children can first accept and then order in ways they can manage as well as call upon as a resource in their ongoing efforts to survive.

These lessons learned are the starting point for helping traumatized children regardless of the format used – individual or group intervention - regardless of the setting – school setting, agency, community mental health, detention, residential settings. Many of these lessons are presented in various publications by Dr. Steele. Attached is a partial reference list of other leaders in the field of trauma who have guided Dr. Steele's work the past twenty years. (References earlier than 1995 are not listed yet earlier discoveries about children's' responses especially to traumatic violent exposure remain relevant today.)

Trauma as an Experience

We want to relate to trauma as an experience, not as a diagnostic category. One word that best captures the experience of trauma is terror. We define the experience of terror as feeling unsafe and powerless to do anything about these situations. Therefore, all intervention must be directed at the restoration of a sense of safety and power.

1. Helping the child experience safety is critical to relieving the experience of trauma.

2. However, safety cannot be experienced through cognitive processes, it must be first experienced at a sensory, implicit level in the mid-brain rather than the neocortex.
3. When a traumatized child's behavior does not make sense, remember the experience of trauma. The one word that best describes the experiences of trauma is terror and terror is feeling totally unsafe and powerless to do anything about the situation. The trauma child's behavior, as illogical as it may seem, is an attempt to gain power over the who or what in his life that is perceived to be a threat and or to get to a safe place that implicitly leaves him with a sense of safety and control (this may be from our view self defeating behavior but is one that is familiar to the child).
4. Trauma is the inability to move the sensory memories of those traumatic experiences from implicit to explicit memory where the child can reframe it in ways he can now manage, use as a resource and look at his life with new meaning.
5. Keep in mind that because the experience of trauma is sensory/implicit, the way we look, approach the child, the pitch of our voice, etc. can remind that child of the bad person who did that bad thing to him. We may be very skilled trauma specialists just not the right person in that child's sensory memory. In trauma work, we need to work in teams when possible so that the child has a choice as to whom he lets help him to feel safer. There is no such thing as resistance in trauma.
6. In the same manner, living in the trauma experience children are unable to cognitively distinguish that the threat is over. In trauma treatment, therefore, we must help the child with the "then" and the "now". Whenever we make a reference to the "then" of his experience we must always bring him to the "now" of his experience this week and/or today. The more frequently we do this, the more the child begins to engage in the same internal process for

himself which then allows for an ending to the current stressful experience that is different from the past traumatic experience.

7. Furthermore, the more frequently the traumatized child can distinguish the present from the past the more opportunities we have to help him reconnect to the future. We must continue to remind every traumatized child that, "today is followed by tomorrow and tomorrow you will…" Here we must be patient and also help the child experience patience for what he hopes for and plans for tomorrow and weeks later.
8. The more often we can help the child identify what he would like to experience tomorrow (keep it realistic and in manageable increments) the more he can begin to move out of the past and move forward to the next day in his life. Point out to him, day after day, the many opportunities he has each day to make choices to do things a little differently or the same things as well.
9. One cannot reduce the mid-brain dominance via cognitive processes alone. These processes are located within the neocortex not in the midbrain where trauma is experienced and stored. The child must first be taught that his body is a resource he can call upon to reduce the psycho physiological experiences of arousal. There are many activities; the simplest being teaching the child to recognize the difference in his body when stressed versus relaxed.
10. By repetitive body conditioning the child can learn that although he may still face difficult situations he can manage his arousal response.
11. Body awareness and control leads to self-regulation, which diminishes mid-brain dominance allowing for frontal cortex development (executive functions, etc.).
12. In trauma treatment children must be directed to their body's response to any stressor, so they can learn to use this response as a control point to begin to reduce their arousal/anxiety via use of past repetitive practice of moving in and out of stressed/relaxed body states. This repetitive

process helps him to distinguish good stress from bad stress, which is an executive function. Problem solving can then be more easily engaged.

13. Increasing a child's time devoted to play, positive fantasies (especially about self as empowered) and increased use of imagination become excellent strategies for reducing midbrain dominance as well as increasing empowerment.
14. In trauma work there is no such thing as resistance – either a child feels safe or he does not. Our responsibility is to be a safe person to be with and to engage in treatment strategies that the child feels safe and in control enough to engage/experience.
15. From a neurological stance, safe experiences strengthen new neuronal connections and repetition of these safe experiences will in time replace the unsafe, sensory memories.
16. Reduction of posttraumatic stress symptoms can be experienced without focusing on symptoms. Begin to restore a sense of safety and power in the child and symptoms will begin to diminish.
17. In trauma treatment we must always provide the child with choice if we are going to help him develop a sense of empowerment.
18. When working at the sensory level we must work hard to see what the child now sees as he looks at himself and the world around as a result of traumatic exposures. We need to see how he now views himself and others, to truly know how to best help as well as not over intervene.
19. It is critical that we do not make assumptions about how that child has been impacted by any experience we think should be traumatic. Remember that an experience is only traumatic if the child's experience of it is one of feeling totally unsafe and powerless to do anything about that situation.
20. We can actually over intervene and induced greater amounts of anxiety then that actually experienced by the child when we assume that we know what it must be like for the child. Ask

two children exposed the same situation what worries them the most since this happened. One will reply, “Does this man we can’t go on our field trip?” while the other replies, “Is mommy going to die too?” One exposure, two different experiences, two different interventions.

21. In trauma, behaviors reflect the sensory experience. These sensory experiences cannot be changed by cognitive interventions alone, as most are not stored in the neocortex but the midbrain. Sensory memories must be changed through sensory interventions if traumatic behavior is to change.
22. When memory cannot be linked linguistically in a contextual framework it remains at a symbolic level where there are no words to describe it. To retrieve that sensory memory so it can be encoded, given a language and then integrated into executive functioning and explicit process (neocortex), it must first be retrieved and externalized in its symbolic, perceptual (iconic) form, an implicit process. This can only be accomplished through sensory interventions.
23. For sensory interventions to be effective they must be structured so each session begins and ends in a safe place while in the middle of the session sensory interventions direct themselves to the specific experiences or themes of trauma: fear and terror, worry, hurt, anger, revenge, accountability, feeling unsafe, powerless and trapped by victim thinking versus survivor thinking.
24. It is critical that the child be actively involved in his own healing process by providing the child the opportunity to:
    a) Focus on internal resources (sensory)
    b) Re-work the experience while at the same time experiencing sensory relief from the terror of that experience(s).
    c) Experience positive, sensory reattachment to their own bodies.

d) Experience at a sensory level a renewed sense of safety and power as a result of engaging in sensory directed experiences.

e) Translate this renewed sense of safety and power into a "cognitive" identity as a survivor and thriver.

f) Cognitive behavioral intervention alone is not as effective as intervention that integrates sensory and cognitive processes. However, cognitive processing must flow from what is first learned by the child at the sensory level.

25. Attempts to cognitively reframe what is not first experienced at a sensory level will not make real sense to the traumatized child simply because the dominant process of the traumatized brain is sensory, not cognitive so understanding, logic, reasoning are difficult to access.

26. Attempts to introduce the reframing statements and thoughts that are not directly related to a sensory experience cannot be internalized. "You tell me I can run a marathon but after ten minutes of jogging for the first time I start having side stitches and have to stop because I'm out of breath. What am I going to believe?" The cognitive conviction flows from the sensory experience. If you had told me I could jog for ten minutes I would have believed you because my body proved it. When you tell me after a few ten-minute body successes that I can now jog for fifteen minutes I will be eager to try because my body, my sensory experience supports the possibility.

27. To cognitively accept oneself as a survivor/thriver, the child must first discover repeatedly, at the sensory level, the ability to regulate his responses to his environment, to his day-to-day interactions within that environment and the situations created by that environment.

28. Cognitively children will generally be far behind their peers as the learning centers do not develop or are not engaged when attempting to survive which is primarily a mid-brain

experience. Once the mid-brain is no longer the predominant processor of daily life, children can often learn at three times the rate compared to when engulfed in trying to survive.

29. Positive reinforcement is often perceived to be very threatening to the traumatized child because he perceives it to be our way of gaining power over him. When he perceives us to have the power he "knows" (sensory memory) he will be hurt by us. Don't be surprised by his response to your positive exchange.

30. We must be genuine with our positive reinforcements but we also must provide them far more frequently then we would normal children. If you have ever been rear-ended you know it takes months to stop looking in your car's rearview mirror every two seconds. It takes months for the body not to tense up the moment you turn the ignition on, to not beeasily startled by every strange noise. You cognitively know the odds are unlikely that you will be rear-eneded again yet your sensory memory tells you differently. Positive reinforcement must be frequent before that traumatized child's sensory memory can be replaced.

31. Educating the child/parent/guardian to the differences between grief and trauma, the way they alter the brain's functions and then normalizing their many reactions within the context of trauma is very critical to do as an initial intervention.

32. Parents/guardians of traumatized children often have trauma histories that are likely to be activated by that child. In these cases they too need to have trauma intervention so as to learn new ways (sensory) to help their child survive while deactivating their own sensory memories When this does not happen traumatized parents will ignore their child's fears and worries, ignore their need for protection and comfort, minimize or even criticize their child's responses all of which further victimize the child (secondary wounding). Educating the parent and system to these experiences of trauma can help prevent further victimization of the child.

33. Working with traumatized children in groups helps children quickly learn they are not alone, that their "problems" are not at all unusual given what they were or are continually exposed to and they can self-regulate their reactions and responses to one another which will be reinforced many times over in the group setting.

34. The group provides for repetitive self-regulating opportunities, which strengthen the sense of empowerment, reduces arousal and the sensory memories, resulting in reaction reduction.

35. However, keep in mind, a group setting may be far too activating for some children dictating the need for individual intervention.

Trauma Informed Care in Group Settings

1. Conducting thorough trauma assessment at admission and throughout a child's treatment process is critical to avoiding those strategies that re-traumatize.
2. All staff must be trained to distinguish trauma related behaviors from other behaviors, the importance of distinguishing between explicit and implicit processes, the neuro-developmental impact of trauma, the importance of titrating interventions, the body's role in healing from trauma, what is meant by "trauma as an experience" versus "trauma as a diagnostic category", why cognitive interventions are limited in their success, knowing how the traumatized child perceives us, the importance of being active not reactive, knowing precisely how our behavior can further victimize the traumatized child.
3. Trauma informed care is not about creating a milieu the traumatized child can fit into, but allowing the child to discover those parts of the milieu that physiologically/neurologically feel the safest and then presenting the child with choices and opportunities to have access to those "parts" of the milieu.

4. Obviously we want to maintain a safe environment at all times but for the traumatized child what might be safe from our view is not safe from his view.
5. There is no such thing as a milieu that brings safety to every child, it is the child who brings his "safe place", "safe poise", "safe interaction" to the milieu and this is reflected in external and internal processing that often presents itself to be "problematic behavior".
6. We cannot possibly assume we know what is best for a traumatized child until we can see a) what he sees when he looks at himself b) see what he sees as he looks at those around him, and c) what he sees when he looks at his environment.
7. This "view" cannot be accomplished by clinical observation alone. There are trauma symptoms that are not always observable and sensory memories for which children have no words to describe.
8. If a child's behavior does not make sense to you, it does not mean that it does not make sense for the child. If we have to ask why behaviors are being repeated, we need to remember the experiences of trauma being one where the child feels unsafe and powerless and that all his efforts are driven by the need to survive (find a safe place, safe person, be able to feel empowered to get what he needs in his world – control).
9. Trauma surviving says, "I must do something to let you know I'm terrified…I will do whatever I need to do to control you and control your responses in order to survive…I will fight any experience, any activity, any person that I see as a threat to me…any person that tries to "control" me because if I let you control me I am vulnerable to your abuse, abandonment, again and again…"
10. To the traumatized child we can be perceived to be a real physical (safety) threat therefore either he avoids us (flight) at all cost or he strikes out assaultively (fights) in hopes of gaining power over us. We can be perceived not as a physical safety threat but a threat to keeping him

from what he wants. When this is his perception he will then engage in a wide variety of behaviors to control our actions/interactions with him.

11. We can be perceived to be no threat at all and as someone the child can get whatever he wants from, whenever he wants. He sees us as easy to manipulate.
12. And then we can be perceived to be of no use to him.
13. To bring about healthy change, trauma informed care dictates that we must all be relevant to that traumatized child. To be relevant we cannot be perceived to be a physical/safety threat, or easily manipulated but someone who has power, who will not hurt the child yet insist that he engage in behaviors that are rewarded with what he wants when that is appropriate, realistically available or doable.
14. To eventually be in the position to give that child new sensory experiences that replaces the old trauma sensory memories and allows him to experience a restoration of that sense of safety and power, we must become the dominant individual in that child's life.
15. To be dominant not controlling (avoiding power struggles) we must, a) be a safe person to be with b) be in control of our emotions, c) provide clearly expressed expectations to that child, d) daily demonstrate our confidence to that child that we can be of helper and, e) that we consistently follow through (In agency settings, traumatized children often spend the majority of their time with adults who themselves have experienced trauma and are easily activated. These are the adults that children perceive to be either a physical/safety threat or easily manipulative, or of no use. These are the adults who will find it difficult to consistently engage the previously describe criteria for establishing dominance.)
16. If traumatized children are viewing us and life as a threat, we need to engage sensory interventions to replace that trauma sensory view.

17. Although engaging sensory activities to calm an aroused child is the intervention of choice, in no way will this prevent the repetition of future arousal responses.
18. To reduce these arousal behaviors we must alter the traumatic sensory memories by changing the child's "iconic" (sensory) identity of self as powerless. Once we can restore that sense of power, a sense of safety follows and thereafter reduction in trauma symptoms and trauma related behaviors.
19. Trauma symptoms and related behaviors are driven by sensory memories not reason, logic, and executive functions. "I am driven by my iconic representation of me" (a victim, powerless, vulnerable, at no time safe).
20. We must replace the body's memory of those traumas with sensory memories that say, "My experience now is safe and empowering."
21. The traumatized child's body will quickly recall those physiological, emotional manifestations of terror, of feeling unsafe and powerless when elements of the environment and people actions trigger these memories. Therefore, we need to know as much as possible about the details of those experiences to identify what elements, behaviors may activate the child.
22. The child's behavior to these triggers in the past may have protected him – he may have run out of the house. However, in a residential setting running can be construed to be truant, uncontrollable, impulsive behavior. In fact, it is behavior that worked in the past. Knowing this, we must now help the child find other acceptable (escape) behavior(s) when he feels threat.
23. However, the first step in changing behavior is to teach the child he can regulate these physiological and emotional reactions by using his body as a resource. Traumatized children need to constantly be directed to their body's response during stressful difficult times as well as during relaxing periods (safe periods). They need to be taught how to control the physiological manifestations of arousal by inducing the physiological manifestations of safety. It is a skill

that must be repeated many times, practiced many times until the child becomes confident that the can call upon this resource at any time.

24. This however is only the first step to helping the child find relief from his tenacious, iconic and sensory trauma memories. These must be replaced by the iconic and sensory experience of self as a survivor and thriver. This can only be accomplished through trauma focused sensory interventions and later confirmed by cognitively reframing those thoughts about self and life he has experienced at a sensory level.
25. Finally, it is critically important that systems overseeing the care of traumatized children also become witnesses to what life is really like for the child. Systems cannot be held accountable for supporting appropriate services and resources until they experience the child and his experiences in the same "sensory" way we as trauma specialists experience that child.

Conclusion

If the lessons learned presented in this paper are not the footing and foundation that supports our interventions with traumatized children there will be little change in the children, little change in the way we interact with the children. TLC's evidenced based research has clearly documented, without question, the remarkable, outstanding, statistically significant gains that traumatized children can see when we meet them in their sensory world whether that be in individual sessions, group sessions, schools, agencies, residential settings. It is not the setting that brings about these changes but focused sensory based trauma interventions that initiate new management of those past experiences through the help of trauma informed staff capable of supporting the trauma principles presented in this article. For further about TLC's evidenced based intervention programs and certification for Trauma and Loss Specialists do contact us at www.tlcinstitute.org or toll-free 1-877-306-5256.

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